RULES
OF
TENNESSEE DEPARTMENT OF HEALTH AND ENVIRONMENT
BUREAU OF MEDICAL CARE SERVICES
DIVISION OF MEDICAID

CHAPTER 1200--13--4
PAYMENT RATES FOR SERVICES PROVIDED TO MEDICAID PATIENTS BY COMMUNITY MENTAL
HEALTH CENTERS
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1200-13-4-.01 PURPOSE. The purpose of these rules and regulations is to establish the administrative procedures for the determination of payments for services provided to Medicaid patients by Community Mental Health Centers. Payments made under the terms of these provisions shall serve as the total amount that a community mental health center can collect for these services.

Authority. *T.C.A. §14-1905.* ***Administrative History****: Original rule filed December 10, 1979; effective January 24, 1980.*

1200-13-4- .02 APPROVAL Only those mental health centers designated by the Department of Health and Environment and the Department of Mental Health and Mental Retardation as rendering services may participate as a provider under these provisions. It is the responsibility of the Department of Health and Environment, the single state agency, to notify the Comptroller of the Treasury and the Department of Mental Health and Mental Retardation when a provider has been admitted to the program and when its participation terminates.

Authority: T.C.A. §14-1905. ***Administrative History:*** Original rule filed December 10, 1979; *effective January 24, 1980.*

1200-13-4-.03 BILLING PROCEDURE. Providers rendering services to Medicaid patients under these provisions shall bill the Department of Health and Environment or their fiscal agents in the manner designated by that Department.

Authority: *T.C.A. §14-1905.* ***Administrative History****: Original rule filed December 10, 1979; effective January 24, 1980.*

1200-l3-4- .04 COVERED SERVICES. The specific items and services covered under the Medicaid program shall be those defined and approved by the Department of Health and Environment in conjunction with the Department of Mental Health and Mental Retardation. Non-covered services may be charged directly to the patient. The patient shall be advised in advance of the non-covered services and shall have the option of accepting the services.

Authority: *T.C.A. §14-1905.* ***Administrative History****: Original rule filed December 10, 1979; effective January 24, 1980.*

1200-13-4-.05 SUBMISSION OF REPORTS OF COSTS AND CHARGES. After the close of each fiscal, year and at other times designated by the Department of Mental Health and Mental Retardation, each Community Mental Health Center provider shall be required to submit to the Department of Mental Health and Mental Retardation a report of costs and charges in the form and manner prescribed by that department covering services for the

preceding fiscal year or designated fiscal period. A new provider who does not have actual figures shall submit budget information appropriately labeled.

Authority: T.C.A. §14-1905. ***Administrative History:*** Original rule filed December 10, 1979; ***effective*** *January 24, 1980.*

1200-13-4-.06 COST REPORT REVIEW. The Department of Mental Health and Mental Retardation shall examine the report of costs and charges of each Community Mental Health Center for mathematical accuracy and to ensure that all non-allowable costs, as stipulated by the Comptroller of the Treasury, the Department of Health and Environment, or the Department of Mental Health and Mental Retardation, have been excluded. Within three months after the close of the fiscal year, the Department of Mental Health and Mental Retardation shall prepare in summary form a report of the cost and charges of the various providers under these provisions and shall present this summary to the Comptroller of the Treasury for review. An extension of the due date may be granted to the Department of Mental Health and Mental Retardation for good cause by the Comptroller of the Treasury.

Authority*: T.C.A. §14-1905.* ***Administrative History****: Original rule filed December 10, 1979; effective January 24,1980.*

1200-13-4-.07 ESTABLISHMENT OF MEDICAID COMMUNITY MENTAL HEALTH CENTER RATES. After reviewing the summary information presented by the Department of Mental Health and Mental Retardation and any other pertinent data, the Comptroller of the Treasury shall establish prospective payment rates for providers under this provision. These rates shall be established subject to further review and audit as provided for in these regulations. The provider shall be limited to reimbursable costs as the maximum it can collect from all sources.

Authority: *T.C.A. §14-1905.* ***Administrative History****: Original rule filed December 10, 1979; effective January 24,1980.*

1200-13-4-.08 INFLATION. An inflation factor may be included in the reimbursement rate. For centers that have completed three full years of program participation, this factor shall be the average of the facility's rate of cost increase over the prior two years limited to the 75th percentile of all such facilities. Negative averages should be considered as zero. The 50th percentile value shall be the factor used for providers that have not completed three full years in the program. The cost increase amount used in determining the 75th and 50th percentile shall be the latest values calculated for all facilities that have participated in the program for three full years.

No inflation factor will be allowed new facilities that have not submitted a cost report covering at least six months of program operations.

The effect of minimum wage and other direct pass through cost items, if any, will be eliminated in the determination of and the application of the cost increase factors.

Authority: *T.C.A. §14-1905.* ***Administrative History****: Original rule filed December 10, 1979; effective January 24, 1980.*

1200-13-4-.09 CHARGES. Each Mental Health Center shall have a fee schedule for services rendered to all patients and shall apply charges to all patients uniformly. However, the basis of payment for services provided Medicaid recipients under these rules shall be the prospective rate established under Rule 1200-13-4-.10 and not the fee charged.

Authority: *T.C.A. §14-1905.* ***Administrative History****: Original rule filed December 10, 1979, effective January 24,1980*

1200-13-4-.10 REIMBURSEMENT RATE CEILINGS. Maximum amount of reimbursable cost payable to a provider as provided by these rules and regulations, shall be the lowest of:

(a) The average of all usual and customary charges of the particular provider for covered services as defined in Rule 1200-13-4-.04 increased by the same inflation factor as used in Rule 1200-13-4-.08.

(b) The average cost of covered services as defined in Rule 1200-13-4-.04 increased by the inflation factor determined in Rule 1200-13-4-.08; or

(c) The maximum program wide rate for covered services as may be established by the Commissioner of the Department of Health and Environment, in consultation with the Commissioner of the Department of Financee and Administration, the Commissioner of the Department of Mental Health and Mental Retardation, and the Comptroller of the Treasury.

Authority: *T.C.4. §14-1905.* ***Administrative History****: Original rule filed December 10, 1979; effective January 24. 1980*

1200-13-4-.11 RETENTION OF RECORDS. Each Community Mental Health Center provider participating under these provisions is required to maintain adequate financial and statistical records which are accurate and in sufficient detail to substantiate the cost data reported. These records must be retained for a period of not less than five years from the date of submission of the report of costs and charges and the provider is required to make such records available upon demand to representatives of the Comptroller of the Treasury, the Department of Health and Environment, the Department Mental Health and Mental Retardation, or the United States Department of Health, Education, and Welfare.

Authority: *T.C.A. §14-1905.* ***Administrative History****: Original rule filed December 10, 1979; effective January 24, 1980.*

1200-13-4-.12 AUDITING OF COST REPORTS. The reports filed in accordance with the rules of this chapter shall be subject to audit by the Comptroller of the Treasury, the Department of Health and Environment, the Department of Mental Health and Mental Retardation, the Department of Health Education, and Welfare or their agents. These reports must provide adequate cost, charge, and statistical data as defined in Rule 1200-13-4-.05. This data must be based on and traceable to the provider's financial and statistical records and to source documents and must be adequate, accurate, and in sufficient detail to support payment made for services rendered to beneficiaries. This data must also be available for and capable of verification in an audit by any of the above parties. The provider must permit the auditors to examine any records and documents necessary to ascertain information pertinent to the determination of the proper amount of program payments due. Data as reflected on the report while cannot be substantiated may be disallowed with reimbursement being required by the provider.

Authority: *T.C.A. §14-1905.* ***Administrative History****: Original rule filed December 10, 1979; effective January 24,1980.*

1200-13-4-.13 NURSING HOME PLAN.

(1) Community Mental Health Centers providing mental health services to Medicaid recipients who reside in a nursing home must have a nursing home plan approved by the Department of Health and Environment and the Department of Mental Health and Mental Retardation.

(a) The plan must contain the following:

1. Documentation, by the Community Mental Health Center (CMHC) staff in the CMHC chart, of efforts made by nursing home staff to deal with problems prior to the client's referral to the mental health center.

2. Identification of the types of clients to be served with an explanation for the selection of these groups.

3. Identification and definition of the type(s) of therapy used in the program.

4. Implementation of treatment time limitations for clients being seen by CMHC staff. The treatment time limitations should include a furlough policy and criteria for those clients to justify the continuation of treatment for more than one year.

(i) *Furlough* - the mechanism for ending treatment for those clients who are not getting better or are deteriorating thus ensuring that short-term specific measurable goals are set and evaluated.

(ii) After six (6) months of therapy, clients that have exhibited no change shall be furloughed for a three-month period. During the furlough period:

(I) All psychotherapy is removed.

(II) CMHC staff shall continue to evaluate the clients each month.

(III) Nursing home staff shall be informed of the furlough and cautioned to inform the CMHC staff of any changes in client's behavior.

(IV) If the client deteriorates, a therapist who confers with the physician/psychiatrist may resume therapy as long as the physician/psychiatrist sees the client within 30 days of the noted deterioration in client's behavior.

(iii) In making furlough determinations for the client, consideration should be given to the following factors:

(I) Is there evidence of improvement after six-months of therapy?

(II) During the furlough, did the client show evidence of improvement?

(III) Does the client have new clinical goals by the six month update? If no new goals are set justification must be made by the physician/psychiatrist for the continuation of therapy beyond six months. The justification should include an assessment that a furlough would be detrimental to the client.

5. Indication of how staff supervision and training will be provided.

6. Specific areas of responsibility delineated in the agreement between nursing home and the CMHC.

(b) After an approved plan is in place, any additions to the plan by a CMHC will require an amendment that must be approved before payment for additional services can be made.

(c) Any payments made for services provided by a CMHC to nursing home patients without approved plan shall be recoverable by the Tennessee Department of Health and Environment.

Authority: *T.C.A. §§71-5-105, 71-5-109 and 4-5-202.* ***Administrative History****: Original rule filed February 21,1991; effective April 7, 1991.*

1200-13-4-.14 TERMINATION OF COMMUNITY MENTAL HEALTH CENTERS RULES. For services provided prior to January 1, 1994, the rules as set out at rule chapter 1200-13-4 shall apply. Effective January 1, 1994, the rules of TennCare as set out at rule chapter 1200-13-12 shall apply. Tennessee Medicaid will continue to pay Medicare premiums, deductibles and copayments in accordance with the Medicaid rules in effect prior to January 1, 1994, and as may be amended.

Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109 and Public Chapter 358 Acts of 1993.* ***Administrative History****: Original rule filed March 18, 1994; effective June 1, 1994*